Beth Block, MFT
4131 Spicewood Springs Rd, Suite A-3
Austin, Texas 78759

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name:_____

I,_____, hereby grant permission to **Beth Block** to:

_____ receive from: _____

_____ release to: _____

_____verbal and/or

_____written information concerning the past and present educational, emotional, and behavioral functioning and treatment of the above named person.

The purpose of this disclosure is:

_____Obtaining information for assessment

_____ Obtaining information for treatment

_____ Insurance or other third party reimbursement

_____ Other: _____

Restrictions (if any):

_____
_____
_____
_____
_____
_____

I may revoke this consent at any time. Revocation does not pertain to previously made disclosures. Release is valid for one year after the date below.

Signature: _____ Date: _____